

ASSEMBLY BILL

No. 2081

Introduced by Assembly Member Coto

February 19, 2008

An act to amend Sections 3351, 4610, and 4610.1 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 2081, as introduced, Coto. Workers' compensation.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment, and requires an employer to provide, or pay for all reasonable costs of, medical services necessary to care for, or relieve work-related injuries. Existing law defines an "employee" for purposes of those provisions to include, among other persons, all officers and members of boards of directors of quasi-public or private corporations while rendering actual service for the corporations for pay, except that when the officers and directors of the private corporation are the sole shareholders of the corporation, the corporation and the officers and directors shall come under the workers' compensation laws only by election, as provided.

This bill would prohibit an officer or director holding less than 10% of the shares of the corporation from excluding himself or herself from workers' compensation coverage required to be provided to other employees of the corporation, and from being subject to the specified election requirement. The bill would provide that, if an officer or director holds more than 10% of the shares of the corporation, the employer shall have the burden of proof of demonstrating that an exclusion of

that officer or director from workers' compensation coverage is appropriate.

Existing law requires every employer to establish a medical treatment utilization review process in compliance with specified requirements, either directly or through the insurer or an entity with which the employer or insurer contracts for these services. Existing law authorizes the administrative director to assess certain administrative penalties if he or she determines that the employer, insurer, or other entity subject to those requirements has failed to meet any of those requirements related to the establishment of the review process.

This bill would prohibit a claims adjuster or a person or entity providing medical bill review services to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation for a referred evaluation or consultation. The bill would also prohibit compensation of a person retained by an employer or insurer claims adjuster or a person retained by an employer or insurer to review or evaluate medical billings from being based on the number of billings, or the cost of services in a billing, that the person has caused or recommended to be denied or limited.

Existing law provides for increased compensation to an injured employee when payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of a workers' compensation award, under specified circumstances.

This bill would additionally entitle an injured worker to increased compensation when the unreasonable delay in the payment of compensation results from a violation of those requirements imposed by the bill that would make it unlawful for a claims adjuster or person or entity providing medical review services to receive compensation or inducement for a referred evaluation or consultation.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) Workers' compensation fraud that is perpetrated by
- 4 unscrupulous employers, claims adjusters, and medical bill review
- 5 services puts legitimate employers at a competitive disadvantage,

1 and causes unnecessary increases in workers' compensation
2 insurance premiums.

3 (b) The Attorney General currently is prosecuting certain
4 employers for violating workers' compensation laws by improperly
5 labeling their employees as shareholding corporate executives.

6 (c) The Fraud Assessment Commission within the Department
7 of Insurance has documented instances of claims adjusters entering
8 into agreements to refer all medical treatment requests to medical
9 bill review services to generate fees.

10 (d) This type of fraudulent conduct causes the workers'
11 compensation system to incur costs estimated to be in the millions
12 of dollars, and may equal or exceed the more highly publicized
13 cases involving claimant fraud.

14 SEC. 2. Section 3351 of the Labor Code is amended to read:

15 3351. "Employee" means every person in the service of an
16 employer under any appointment or contract of hire or
17 apprenticeship, express or implied, oral or written, whether lawfully
18 or unlawfully employed, and includes:

19 (a) Aliens and minors.

20 (b) All elected and appointed paid public officers.

21 (c) (1) All officers and members of boards of directors of
22 quasi-public or private corporations while rendering actual service
23 for the corporations for pay; ~~provided that, where. However, when~~
24 the officers and directors of the private corporation are the sole
25 shareholders ~~thereof of the corporation~~, the corporation and the
26 officers and directors shall come under the compensation provisions
27 of this division only by election as provided in subdivision (a) of
28 Section 4151.

29 (2) *Notwithstanding paragraph (1), an officer or director*
30 *holding less than 10 percent of the shares of the corporation shall*
31 *not exclude himself or herself from workers' compensation*
32 *coverage applicable to other employees, nor shall the officer or*
33 *director be subject to the election provision in subdivision (a) of*
34 *Section 4151.*

35 (3) *If an officer or director holds more than 10 percent of the*
36 *shares of the corporation, the employer shall have the burden of*
37 *proof of demonstrating that the exclusion of that officer or director*
38 *from workers' compensation coverage is appropriate under this*
39 *subdivision.*

(d) Except as provided in subdivision (h) of Section 3352, any person employed by the owner or occupant of a residential dwelling whose duties are incidental to the ownership, maintenance, or use of the dwelling, including the care and supervision of children, or whose duties are personal and not in the course of the trade, business, profession, or occupation of the owner or occupant.

(e) All persons incarcerated in a state penal or correctional institution while engaged in assigned work or employment as defined in paragraph (1) of subdivision (a) of Section 10021 of Title 8 of the California Code of Regulations, or engaged in work performed under contract.

(f) All working members of a partnership or limited liability company receiving wages irrespective of profits from the partnership or limited liability company; provided that where the working members of the partnership or limited liability company are general partners or managers, the partnership or limited liability company and the partners or managers shall come under the compensation provisions of this division only by election as provided in subdivision (a) of Section 4151. If a private corporation is a general partner or manager, “working members of a partnership or limited liability company” shall include the corporation and the officers and directors of the corporation, provided that the officers and directors are the sole shareholders of the corporation. If a limited liability company is a partner or member, “working members of the partnership or limited liability company” shall include the managers of the limited liability company.

(g) For the purposes of subdivisions (c) and (f), the persons holding the power to revoke a trust as to shares of a private corporation or as to general partnership or limited liability company interests held in the trust, shall be deemed to be the shareholders of the private corporation, or the general partners of the partnership, or the managers of the limited liability company.

SEC. 3. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, “utilization review” means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively,

1 or concurrent with the provision of medical treatment services
2 pursuant to Section 4600.

3 (b) Every employer shall establish a utilization review process
4 in compliance with this section, either directly or through its insurer
5 or an entity with which an employer or insurer contracts for these
6 services.

7 (c) Each utilization review process shall be governed by written
8 policies and procedures. These policies and procedures shall ensure
9 that decisions based on the medical necessity to cure and relieve
10 of proposed medical treatment services are consistent with the
11 schedule for medical treatment utilization adopted pursuant to
12 Section 5307.27. Prior to adoption of the schedule, these policies
13 and procedures shall be consistent with the recommended standards
14 set forth in the American College of Occupational and
15 Environmental Medicine Occupational Medical Practice
16 Guidelines. These policies and procedures, and a description of
17 the utilization process, shall be filed with the administrative director
18 and shall be disclosed by the employer to employees, physicians,
19 and the public upon request.

20 (d) If an employer, insurer, or other entity subject to this section
21 requests medical information from a physician in order to
22 determine whether to approve, modify, delay, or deny requests for
23 authorization, the employer shall request only the information
24 reasonably necessary to make the determination. The employer,
25 insurer, or other entity shall employ or designate a medical director
26 who holds an unrestricted license to practice medicine in this state
27 issued pursuant to Section 2050 or Section 2450 of the Business
28 and Professions Code. The medical director shall ensure that the
29 process by which the employer or other entity reviews and
30 approves, modifies, delays, or denies requests by physicians prior
31 to, retrospectively, or concurrent with the provision of medical
32 treatment services, complies with the requirements of this section.
33 Nothing in this section shall be construed as restricting the existing
34 authority of the Medical Board of California.

35 (e) No person other than a licensed physician who is competent
36 to evaluate the specific clinical issues involved in the medical
37 treatment services, and where these services are within the scope
38 of the physician's practice, requested by the physician may modify,
39 delay, or deny requests for authorization of medical treatment for
40 reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements must be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including,

1 but not limited to, the potential loss of life, limb, or other major
2 bodily function, or the normal timeframe for the decisionmaking
3 process, as described in paragraph (1), would be detrimental to the
4 employee's life or health or could jeopardize the employee's ability
5 to regain maximum function, decisions to approve, modify, delay,
6 or deny requests by physicians prior to, or concurrent with, the
7 provision of medical treatment services to employees shall be made
8 in a timely fashion that is appropriate for the nature of the
9 employee's condition, but not to exceed 72 hours after the receipt
10 of the information reasonably necessary to make the determination.

11 (3) (A) Decisions to approve, modify, delay, or deny requests
12 by physicians for authorization prior to, or concurrent with, the
13 provision of medical treatment services to employees shall be
14 communicated to the requesting physician within 24 hours of the
15 decision. Decisions resulting in modification, delay, or denial of
16 all or part of the requested health care service shall be
17 communicated to physicians initially by telephone or facsimile,
18 and to the physician and employee in writing within 24 hours for
19 concurrent review, or within two business days of the decision for
20 prospective review, as prescribed by the administrative director.
21 If the request is not approved in full, disputes shall be resolved in
22 accordance with Section 4062. If a request to perform spinal
23 surgery is denied, disputes shall be resolved in accordance with
24 subdivision (b) of Section 4062.

25 (B) In the case of concurrent review, medical care shall not be
26 discontinued until the employee's physician has been notified of
27 the decision and a care plan has been agreed upon by the physician
28 that is appropriate for the medical needs of the employee. Medical
29 care provided during a concurrent review shall be care that is
30 medically necessary to cure and relieve, and an insurer or
31 self-insured employer shall only be liable for those services
32 determined medically necessary to cure and relieve. If the insurer
33 or self-insured employer disputes whether or not one or more
34 services offered concurrently with a utilization review were
35 medically necessary to cure and relieve, the dispute shall be
36 resolved pursuant to Section 4062, except in cases involving
37 recommendations for the performance of spinal surgery, which
38 shall be governed by the provisions of subdivision (b) of Section
39 4062. Any compromise between the parties that an insurer or
40 self-insured employer believes may result in payment for services

1 that were not medically necessary to cure and relieve shall be
2 reported by the insurer or the self-insured employer to the licensing
3 board of the provider or providers who received the payments, in
4 a manner set forth by the respective board and in such a way as to
5 minimize reporting costs both to the board and to the insurer or
6 self-insured employer, for evaluation as to possible violations of
7 the statutes governing appropriate professional practices. No fees
8 shall be levied upon insurers or self-insured employers making
9 reports required by this section.

10 (4) Communications regarding decisions to approve requests
11 by physicians shall specify the specific medical treatment service
12 approved. Responses regarding decisions to modify, delay, or deny
13 medical treatment services requested by physicians shall include
14 a clear and concise explanation of the reasons for the employer's
15 decision, a description of the criteria or guidelines used, and the
16 clinical reasons for the decisions regarding medical necessity.

17 (5) If the employer, insurer, or other entity cannot make a
18 decision within the timeframes specified in paragraph (1) or (2)
19 because the employer or other entity is not in receipt of all of the
20 information reasonably necessary and requested, because the
21 employer requires consultation by an expert reviewer, or because
22 the employer has asked that an additional examination or test be
23 performed upon the employee that is reasonable and consistent
24 with good medical practice, the employer shall immediately notify
25 the physician and the employee, in writing, that the employer
26 cannot make a decision within the required timeframe, and specify
27 the information requested but not received, the expert reviewer to
28 be consulted, or the additional examinations or tests required. The
29 employer shall also notify the physician and employee of the
30 anticipated date on which a decision may be rendered. Upon receipt
31 of all information reasonably necessary and requested by the
32 employer, the employer shall approve, modify, or deny the request
33 for authorization within the timeframes specified in paragraph (1)
34 or (2).

35 (h) Every employer, insurer, or other entity subject to this section
36 shall maintain telephone access for physicians to request
37 authorization for health care services.

38 (i) If the administrative director determines that the employer,
39 insurer, or other entity subject to this section has failed to meet
40 any of the timeframes in this section, or has failed to meet any

1 other requirement of this section, the administrative director may
2 assess, by order, administrative penalties for each failure. A
3 proceeding for the issuance of an order assessing administrative
4 penalties shall be subject to appropriate notice to, and an
5 opportunity for a hearing with regard to, the person affected. The
6 administrative penalties shall not be deemed to be an exclusive
7 remedy for the administrative director. These penalties shall be
8 deposited in the Workers' Compensation Administration Revolving
9 Fund.

10 *(j) A claims adjuster or a person or entity providing medical*
11 *bill review services shall not offer, deliver, receive, or accept any*
12 *rebate, refund, commission, preference, patronage dividend,*
13 *discount, or other consideration, whether in the form of money or*
14 *otherwise, as compensation or inducement for a referred evaluation*
15 *or consultation.*

16 *(k) Compensation of a person retained by an employer or insurer*
17 *to review medical billings shall not be based on the number of*
18 *billings, or the cost of services in a billing, that the person has*
19 *caused or recommended to be denied or limited. Any request for*
20 *compensation by a person retained to review medical billings that*
21 *is in violation of this subdivision shall be a prima facie violation*
22 *of subdivision (j).*

23 SEC. 4. Section 4610.1 of the Labor Code is amended to read:

24 4610.1. An employee shall not be entitled to an increase in
25 compensation under Section 5814 for unreasonable delay in the
26 provision of medical treatment for periods of time necessary to
27 complete the utilization review process in compliance with Section
28 4610. A determination by the appeals board that medical treatment
29 is appropriate shall not be conclusive evidence that medical
30 treatment was unreasonably delayed or denied for purposes of
31 penalties under Section 5814. In no case shall this section preclude
32 an employee from entitlement to an increase in compensation under
33 Section 5814 when an employer has unreasonably delayed or
34 denied medical treatment due to an unreasonable delay in
35 completion of the utilization review process set forth in Section
36 4610 *or when the unreasonable delay results from a violation of*
37 *subdivision (j) of Section 4610.*

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